

# GP Referral Form



Aboriginal Health

## WA Integrated Team Care Program

The Integrated Team Care (ITC) Program supports Aboriginal and Torres Strait Islander people with complex chronic care needs to improve self-management of their condition in partnership with their GP. See HealthPathways for further information.<sup>v</sup>

### Referring GP Details: (stamp accepted)

Name:

Practice:

Practice Address:

Phone:

Fax:

### Patient Details:

First Name:

Date of Birth:

Surname:

Phone:

Residential Address:

Postcode:

Next of Kin/Alternate Contact:

Alternate Contact Phone:

### My patient fulfils ALL the criteria below:

- Is Aboriginal and/or Torres Strait Islander
- Has chronic health needs requiring complex and/or multidisciplinary care
- Is enrolled for Chronic Disease Management (CDM) with their GP - *select relevant and attach plans with referral*
  - a) **preferred:** Has a **GP Management Plan MBS721<sup>i</sup>**; and/or
  - b) Team Care Arrangements MBS723; or has
  - c) current Aboriginal Health Check MBS715 and is registered for PIP IHI for CDM with referring practice<sup>ii</sup>; or
  - d) is being referred by non-usual GP or Remote Area Nurse (RAN) with an interim<sup>iii</sup> CDM care plan.

Note: referral options b) - d) must provide a GP Management Plan MBS721 within three months.

### Chronic Condition Details (tick as applicable to patient)

- Diabetes
- Cardiovascular disease
- Cancer
- Other<sup>iv</sup> – specify:
- Eye health condition associated with diabetes
- Chronic kidney disease
- Chronic respiratory disease

Is another organisation already currently providing Care Coordination? If yes, specify:

Eg. Aboriginal Community Controlled Health Service; ICDC Program. Provide Client ID Number if available.

### NDIS and Aged Care:

Is the client registered for NDIS:  Yes  No  In progress

Is the client registered for Aged Care support:  Yes, Level:  No  In progress

### Reason/s for ITC Referral:<sup>v</sup>

- Requires Supplementary Services support
- Requires Care Coordination support

**THE ITC PROGRAM IS ONLY ABLE TO PROVIDE SUPPORT RECOMMENDED IN THE GP CARE PLAN AND NOT AVAILABLE THROUGH OTHER MEANS.**

Provide brief detail as per care plan:

Eg. Ulcerated foot. Request Medicare Gap payment support for 2 x Podiatrist services. Upcoming appointment 18/4/18.

### Patient Information and Consent

My GP has explained the purpose of this referral for the ITC Program; I give permission for my care plan to be shared with the ITC Provider; and for the ITC Provider to contact me to discuss how the ITC Program can support me in my care plan needs.

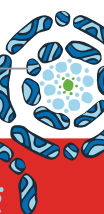
Patient signature:<sup>vi</sup>

GP signature:<sup>vii</sup>

Verbal consent (where signature not practicable)  <sup>vi</sup>

Date:

**Forward completed ITC Referral Form, patient care plan and other relevant documents to ITC Provider**



**See below for examples of potential ITC support.  
Include ALL relevant recommendations in care plan.**

**Requested Care Coordination support could include:**

Help client arrange appointments for chronic condition management	<i>Eg. GPMP Reviews with usual GP, diagnostic tests, pharmacy review, allied health and specialist visits.</i>
	<i>Forward all relevant documents with WA ITC Referral Form:</i>
	<ul style="list-style-type: none"> <li>• <u>Copy of GP Care Plan;</u></li> <li>• <u>Upcoming appointment dates</u></li> <li>• <u>Team Care Arrangements;</u></li> <li>• <u>Allied Health Medicare CDM Referral Form;</u></li> <li>• <u>Allied Health Medicare Referral Form (linked to MBS715);</u></li> <li>• <u>Copy of named/preferred provider referral forms</u></li> </ul>
Clinical service	<i>Eg. Clinical observations (BMI, BP, etc), health promotion, contribute to care planning, condition monitoring, self-management support.</i>
Case Conferencing/Management	<i>Eg. Support practice staff to arrange case conferencing; participate in case conferencing and team care.</i>
Attend initial appointments with client	<i>Eg. Support client to become comfortable in new clinical setting, overcome language barriers, understand clinical language; provide cultural brokerage.</i>
Provide client education on chronic condition/s and care plan	<i>Eg. Medication, treatment regimen</i>
Link client with general wellbeing and holistic care support	<i>Eg. Women's/men's support groups, social and emotional wellbeing support, cultural healing.</i>
Arrange transport for access to chronic condition management appointments	<i>Where the client doesn't already have access to alternative transport.</i>

**Requested Supplementary Services support could include:**

Provide financial assistance to enable access to approved medical equipment	<i>Eg. Approved aids include: Assisted breathing equipment, blood sugar/glucose monitoring equipment, dose administration aids, medical footwear as prescribed and fitted by podiatrist, mobility aids, spectacles. <u>Note:</u> Requests for CPAP require Sleep Study and trial of CPAP before ITC support to access CPAP can be considered.</i>
Provide financial assistance to enable access to specialist/allied health professional services	<i>Where it has been indicated that patient is financially unable to access clinically necessary services for the management of their chronic condition; and/or patient has exhausted available Medicare Allied Health items.</i>
Provide transport for access to chronic condition management appointments	<i>Where the client doesn't already have access to alternative transport.</i>

**THE SUPPORT RECOMMENDED WILL BE ASSESSED BY A CARE COORDINATOR AND APPROVED BASED ON CLIENT NEED AND PROGRAM CAPACITY.**

**FORWARD REFERRAL TO APPROPRIATE ITC REGION – see HealthPathways<sup>v</sup> for Provider details  
ITC Providers will forward referrals received for clients of other ITC regions to the correct ITC Provider**

Perth Metro – North West, South East, Inner Metro	Perth Metro – North East, South West
Perth Metro – South West	Kimberley
Pilbara	Goldfields
Midwest - North	Midwest - South
Wheatbelt – Coastal, Eastern, Western Wheatbelt	South West
Wheatbelt – Southern Wheatbelt	Great Southern

- <sup>i</sup> Or equivalent from a Health Care Home practice
- <sup>ii</sup> Must be registered for the component of PIP IHI for patients with a chronic condition – not for PBS CoPayment alone.
- <sup>iii</sup> GP or RAN may submit an interim care plan (eg. carried out during a long consult) for patients without access to their usual GP. The plan must be comprehensive, relevant to client's CDM, and include recommended ITC support.
- <sup>iv</sup> As per the MBS, an eligible condition is one that has been, or is likely to be, present for at least six months
- <sup>v</sup> See ITC HealthPathways for further information – [https://wa.healthpathways.org.au/65938.htm?zoom\\_highlight=integrated+team+care++itc](https://wa.healthpathways.org.au/65938.htm?zoom_highlight=integrated+team+care++itc), (username: connected; password: healthcare).
- <sup>vi</sup> Verbal consent should only be used where it is not practicable to obtain written consent

